

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297068		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2009	
NAME OF PROVIDER OR SUPPLIER CARING NURSES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2968 EAST RUSSELL ROAD LAS VEGAS, NV 89120			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 000	<p>INITIAL COMMENTS</p> <p>This Statement of Deficiencies was generated as a result of the Medicare Recertification Survey conducted at your agency on January 5, 2009 through January 8, 2009.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p> <p>The current census at the time of the survey was 422. Twenty seven clinical records were reviewed. Twelve home visits were conducted.</p> <p>The agency met all Conditions of Participation:</p> <p>The following regulatory deficiencies were identified:</p>			G 000			
G 104	<p>484.10(b)(1)&(2) EXERCISE OF RIGHTS AND RESPECT FOR PROP</p> <p>The patient has the right to exercise his or her rights as a patient of the HHA. The patient's family or guardian may exercise the patient's rights when the patient has been judged incompetent.</p> <p>This STANDARD is not met as evidenced by: Based on clinical record review, policy review and staff interview, the agency failed to obtain a copy of the patient's power of attorney, or advanced directive for 1 of 27 patients sampled. (#1).</p> <p>Findings include:</p>			G 104			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2009
NAME OF PROVIDER OR SUPPLIER CARING NURSES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2968 EAST RUSSELL ROAD LAS VEGAS, NV 89120		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 104	Continued From page 1 Patient #1 was admitted to the agency on 11/12/08 with diagnoses including Alzheimer's dementia, muscle weakness, hypertension, and a history of frequent falls. Record review revealed that the patient was confused, and requires assistance for all of the activities of daily living. The patient was unable to perform any instrumental activities of daily living. Clinical record review revealed that the patient's daughter had a medical durable power of attorney to make healthcare decisions for the patient. A section of the admission contract titled: "Advance Directives." The line that read :I have executed a Medical Durable Power of Attorney and will provide the agency with a copy yes/no. The no box was checked. The Director of Patient Care services was interviewed on 1/5/08 at 4:15 PM and reported that the nurse should have made an effort to obtain a copy of the patient's power of attorney document. The admission documents were signed by the patient and his wife. The patient's wife also reported that her daughter had power of attorney for her as well. Review of the facility's policy titled "Patient and Family Information Advance Medical Directives" read: Implementation of Advance Directives will take effect when a copy of the directive was recieved by the agency. This copy will be kept in the patient's clinical record. Information: If you already have a Power of Attorney for Healthcare, it was important that you provide the agency with a copy of the document for your medical record.	G 104			
G 145	484.14(g) COORDINATION OF PATIENT	G 145			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2009
NAME OF PROVIDER OR SUPPLIER CARING NURSES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2968 EAST RUSSELL ROAD LAS VEGAS, NV 89120		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 145	<p>Continued From page 2 SERVICES</p> <p>A written summary report for each patient is sent to the attending physician at least every 60 days.</p> <p>This STANDARD is not met as evidenced by: Based on clinical record review, observation, staff and patient interview, the agency failed to ensure the written summary to the physician met the regulatory definition of a summary requiring a written summary that accurately reflected the patient's current condition for 1 of 27 patients sampled. (#17).</p> <p>Findings include:</p> <p>Subpart A- General Provision</p> <p>CFR 484.2 Definition:</p> <p>Summary report means the compilation of the pertinent factors of a patient's clinical notes and progress notes that is submitted to the patient's physician.</p> <p>Patient #17 was admitted on 11/4/08 with diagnoses of diabetes mellitus, neuropathy in diabetes, difficulty walking, multiple myeloma, coronary artery disease, and decubitus ulcer.</p> <p>During a home visit on 1/7/09, the home health nurse treated a wound on the left arm of the patient with the following treatment: cleansed with normal saline, applied Mupirocin 2% ointment and covered with Telfa wrapped with Kerlix and net applied. The clinical record lacked documented evidence to verify the nurse included left arm wound treatment in the 60 day summary</p>	G 145			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2009
NAME OF PROVIDER OR SUPPLIER CARING NURSES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2968 EAST RUSSELL ROAD LAS VEGAS, NV 89120		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 145	Continued From page 3 submitted to the physician. The plan of care, dated 11/4/08 indicated the patient had Port-A- Cath (a type of venous access device) care at the physician office. During an interview with the spouse, patient and home health nurse on 1/7/09, the surveyor asked when the patient was last seen by the oncologist. The spouse stated the patient was seen a few weeks ago. The surveyor asked the nurse about Port a cath care provided by the home health agency between physician's visits. The nurse thought the oncologist office was caring for it. The clinical record lacked documented evidence to verify the nurse included the status of the Port- A- Cath in the 60 day summary submitted to the physician.	G 145			
G 157	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. This STANDARD is not met as evidenced by: Based on review of clinical records, policy review and interview with agency staff, it was determined the agency failed to ensure the patient's medical, nursing and social needs were met in the patient's place of residence in 1 of 27 patient's reviewed. (#3) Findings include: The agency policy titled: Start of care policy for therapist and MSW revealed the following:	G 157			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2009
NAME OF PROVIDER OR SUPPLIER CARING NURSES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2968 EAST RUSSELL ROAD LAS VEGAS, NV 89120		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 157	Continued From page 4 POLICY: The purpose of this policy is to establish a time frame relative to start of care after a referral is made to a Therapist or MSW. The start of Therapy and MSW Evaluation will be done within 72 hours (excluding Saturdays, Sundays, and holidays) after the day the Therapist & MSW is given the referral. This policy was last revised on 2/09/07 Patient #3 was admitted to the agency on 7/12/08 with diagnoses of diabetes without complications, muscle weakness, hypertension and organic brain syndrome. The plan of care dated 7/12/08 contained orders for skilled nursing of 2/wk x 1wk (two times a week for one week) and 1/wk x 9wks (one time a week for nine weeks). The record also contained orders for other disciplines required: Physical Therapist to consult, evaluate and treat. The patient was not seen by physical therapy for evaluation for 11 days following the initial evaluation by skilled nursing.	G 157			
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on clinical record review, policy review and staff interview, the agency failed to notify the physician of changes to the plan of care for 4 of	G 158			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2009
NAME OF PROVIDER OR SUPPLIER CARING NURSES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2968 EAST RUSSELL ROAD LAS VEGAS, NV 89120		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 158	<p>Continued From page 5</p> <p>27 patients sampled. (#5, #1, #7, #24)</p> <p>Findings include:</p> <p>The agency policy titled "Missed visit report", revealed the following:</p> <p>POLICY:</p> <p>The Missed visit Report will be utilized when disciplines are unable to make scheduled visits. Each discipline will contact a Nurse Manager immediately with an appropriate reason as to why the patient cannot be visited.</p> <p>Patient #5 was admitted to the agency on 11/3/07 with diagnoses including chronic obstructive airway disease, lung cancer, and muscle weakness.</p> <p>The patients plan of care dated 6/30/08 through 8/28/08 revealed: skilled nursing visit frequency once a week for nine weeks. The skilled nurse conducted visits weekly except for 7/2/08 and 7/22/08. A "Missed Visit Report" form was found for both of these dates. The form contained no documented evidence that the physician had been notified of the missed visits except for a check marked box next to "Notified M.D." on the missed visit report for 7/22/08. The box was not checked for the missed visit on 7/2/08.</p> <p>Patient #1 was admitted to the agency on 11/12/08 with diagnoses including Alzheimer's dementia, muscle weakness, hypertension, and a history of falls.</p> <p>The patient's plan of care for 11/12/08 through 1/10/09 revealed: skilled nurse visit frequency two</p>	G 158			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2009
NAME OF PROVIDER OR SUPPLIER CARING NURSES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2968 EAST RUSSELL ROAD LAS VEGAS, NV 89120		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 158	<p>Continued From page 6</p> <p>visits per week, for two weeks, and then one visit per week for eight weeks. The visits were conducted as ordered except for a missed visit on 11/20/08. The form contained no evidence that the physician had been notified of the missed visit except for a check marked box next to "Notified M.D." on the missed visit report.</p> <p>The administrator/Director of Patient Care Services was interviewed on 1/5/08 at 4:00 PM. She reported that she "was not sure that the patients physician had been notified, but that if the nurse had checked the box that corresponded with the notified M.D. line, she felt that the physician was probably notified" of the missed visits. She further reported that the the form should be filled completely including the name of the physician that was notified and the time and date of notification.</p> <p>Record review revealed that the nurse manager had signed the incomplete missed visit reports for patients #1 and #5.</p> <p>Review of the facility's policy titled "change of frequency/duration/type" read: Visit will be provided to the patient consistent with the Plan of Care signed by the physician. If visits are ordered by ranges and the professional judgement of the nurse. Supported by documentation in the clinical notes, visits may be decreased by making a notation in the response section of the skilled nursing visit note and a doctor's order must be presented in the record."</p> <p>Clinical record review revealed lack of documented evidence of physician's order for any of the missed visits for patients #1 and #5. Patient #7 was admitted to the agency on</p>	G 158			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2009
NAME OF PROVIDER OR SUPPLIER CARING NURSES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2968 EAST RUSSELL ROAD LAS VEGAS, NV 89120		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 158	Continued From page 7 10/28/08 with diagnoses of aftercare for healing trauma, abnormality of gait, muscle weakness, other specific organic brain syndrome, hypertension, and unspecified osteoporosis. The plan of care, dated 10/28/08 through 12/26/08 indicated: skilled nurse (SN) frequency: 2 times a week for 4 weeks; 1 time a week for 5 weeks. The skilled nurse conducted one home visit during the first week of service, not two as per the physician's orders. During the week starting 11/15/08, the skilled nurse conducted one home visit, not two as per the physician's order. The Clinical record lacked documented evidence that the physician had been notified of the change to the plan of care. Patient #24 was admitted on 11/24/08 with diagnoses including malignant neoplasm of the breast, rheumatoid arthritis, fibromyalgia, and idiopathic peripheral neuropathy. Patient #24's plan of care, dated 11/24/08 through 1/22/09, ordered skilled nursing visits with a frequency of 1 visit a week for 9 weeks. A skilled nursing visit was completed on 11/24/08, 12/5/08, 12/10/08, and 12/17/08. No visits were made during the weeks of 12/20/08 and 12/27/08 due to "pt (patient) has refused any SN (skilled nursing) visits over holidays". There was no documented evidence the physician was notified of the changes to the plan of care.	G 158			
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and	G 159			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2009
NAME OF PROVIDER OR SUPPLIER CARING NURSES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2968 EAST RUSSELL ROAD LAS VEGAS, NV 89120		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 159	<p>Continued From page 8</p> <p>equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>This STANDARD is not met as evidenced by: Based on interview with agency staff and review of clinical records, the agency failed to ensure the plan of care from certification period to certification period covered changes in all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge and goals for 3 of 27 records reviewed. (#17, #7, #6)</p> <p>Findings include:</p> <p>Patient #17 was admitted on 11/4/08 with diagnoses of diabetes mellitus, neuropathy in diabetes, difficulty walking, multiple myeloma, coronary artery disease, and decubitus ulcer.</p> <p>The initial plan of care for Patient #17, dated 11/4/08 through 1/2/09 revealed: Skilled nurse: teach and perform observation and assessment for: -complication of disease process -rationale for compliance with diet/activities /medications/treatment -safety with activities and activities of daily living</p>	G 159			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2009
NAME OF PROVIDER OR SUPPLIER CARING NURSES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2968 EAST RUSSELL ROAD LAS VEGAS, NV 89120		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 159	<p>Continued From page 9</p> <ul style="list-style-type: none"> -effective hygiene care -signs and symptoms of infection -effective pain management -wound care using aseptic technique <p>Treatment:</p> <ul style="list-style-type: none"> -Port- A -Cath care at MD office <p>Goal/Rehabilitation Potential/Discharge Plans continued</p> <p>Medications and Treatment this certification period</p> <ul style="list-style-type: none"> -Patient/Caregiver will demonstrate safety measures with ambulation and activities of daily living -Patient/Caregiver will demonstrate effective hygiene -Patient/Caregiver will remain free of infection -Patient/Caregiver will verbalize and demonstrate effective pain control at the patient's own comfort level as verbalized by patient/ caregiver -Patient/Caregiver will verbalize and demonstrate effective wound care application while observing proper aseptic technique. <p>The recertification Plan of Care for Patient #17, dated 1/3/09 through 3/3/09 indicated:</p> <p>Skilled nurse: teach and perform observation and assessment for:</p> <ul style="list-style-type: none"> -complication of disease process -rationale for compliance with diet/activities /medications/treatment -safety with activities and activities of daily living -effective hygiene care -signs and symptoms of infection -effective pain management -wound care using aseptic technique 	G 159			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2009
NAME OF PROVIDER OR SUPPLIER CARING NURSES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2968 EAST RUSSELL ROAD LAS VEGAS, NV 89120		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 159	<p>Continued From page 10</p> <p>Treatment:</p> <p>-Port- A -Cath care at MD office</p> <p>Goal/Rehabilitation Potential/Discharge Plans continued</p> <p>Medications and Treatment this certification period</p> <p>-Patient/Caregiver will demonstrate safety measures with ambulation and activities of daily living</p> <p>-Patient/Caregiver will demonstrate effective hygiene care</p> <p>-Patient/Caregiver will remain free of infection</p> <p>-Patient/Caregiver will verbalize and demonstrate effective pain control at the patient's own comfort level as verbalized by patient/ caregiver</p> <p>-Patient/Caregiver will verbalize and demonstrate effective wound care application while observing proper aseptic technique.</p> <p>The skilled nurse failed to ensure the plan of care from certification period to certification period covered changes in types of services, and medications, treatments and goals/rehabilitation potential/discharge plans.</p> <p>Patient #7 was admitted on 10/28/08 with diagnoses of aftercare for healing trauma, abnormality of gait, muscle weakness, other specified organic brain syndrome, hypertension, and unspecified osteoporosis.</p> <p>The initial plan of care for Patient #7, dated 10/28/08 through 12/26/08 revealed:</p> <p>Skilled nurse: teach and perform observation and assessment for:</p> <p>-complication of disease process</p> <p>-rationale for compliance with diet/activities /medications/treatment</p>	G 159			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2009
NAME OF PROVIDER OR SUPPLIER CARING NURSES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2968 EAST RUSSELL ROAD LAS VEGAS, NV 89120		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 159	<p>Continued From page 11</p> <ul style="list-style-type: none"> -safety with activities and activities of daily living -effective hygiene care -signs and symptoms of infection -effective pain management <p>Goal/Rehabilitation Potential/Discharge Plans continued</p> <p>Medications and Treatment this certification period</p> <ul style="list-style-type: none"> -Patient/Caregiver will verbalize and demonstrate the importance of diet, activities, medications and treatment -Patient/Caregiver will demonstrate safety measures with ambulation and activities of daily living -Patient/Caregiver will demonstrate effective hygiene care -Patient/Caregiver will remain free of infection -Patient/Caregiver will verbalize and demonstrate effective pain control at the patient's own comfort level as verbalized by patient/ caregiver <p>The recertification plan of care for Patient #7, dated 12/27/08 through 2/24/09 revealed:</p> <p>Skilled nurse: teach and perform observation and assessment for:</p> <ul style="list-style-type: none"> -complication of disease process -rationale for compliance with diet/activities /medications/treatment -safety with activities and activities of daily living -effective hygiene care -signs and symptoms of infection -effective pain management <p>Goal/Rehabilitation Potential/Discharge Plans continued</p> <p>Medications and Treatment this certification period</p> <ul style="list-style-type: none"> -Patient/Caregiver will verbalize and demonstrate 	G 159			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2009
NAME OF PROVIDER OR SUPPLIER CARING NURSES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2968 EAST RUSSELL ROAD LAS VEGAS, NV 89120		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 159	<p>Continued From page 12</p> <p>the importance of diet, activities, medications and treatment</p> <ul style="list-style-type: none"> -Patient/Caregiver will demonstrate safety measures with ambulation and activities of daily living -Patient/Caregiver will demonstrate effective hygiene care -Patient/Caregiver will remain free of infection -Patient/Caregiver will verbalize and demonstrate effective pain control at the patient's own comfort level as verbalized by patient/ caregiver <p>The skilled nurse failed to ensure the plan of care from certification period to certification period changed in types of services, and medications and treatments. All of the clinical records reviewed lacked documented evidence that the agency individualized the plans of care for each patient.</p> <p>Patient #6 was admitted to the agency on 10/13/07 and continued to be seen for over a one year period by the agency. The current plan of care for Patient #6 was dated 12/06/08 through 2/03/09 with diagnoses of fitting urinary devices, urinary incontinence, and deep vein thrombosis, diabetes without complications, hypertension, muscle weakness and difficulty with ambulation. The patient was being seen three times a week by skilled nursing.</p> <p>An interview was conducted with the registered nurse of Patient #6 on 1/06/09 at 3 PM. When asked about the difference between the plan of care order for flushing and the actual treatment being provided, she stated that the physician had ordered the change about 6 months ago and she was sure that she had written an order to update the plan of care. She also stated that there was a problem with the agency updating the plans of</p>	G 159			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297068		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2009	
NAME OF PROVIDER OR SUPPLIER CARING NURSES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2968 EAST RUSSELL ROAD LAS VEGAS, NV 89120			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 159	Continued From page 13 care on the patients when there were changes. During an interview with the Director of Professional Services/Administrator, the owner and the quality improvement staff conducted on 1/06/09 at 4:00 PM, the following information was revealed. They were insistent that the order was written for 3 times a week. The surveyor pointed out the section on the plan of care for treatment that documented the flush order was twice a week. The skilled nursing frequency was 3 times a week. The Director of Patient Care Services agreed that the plans of care had not been updated as appropriate. The patient also stated that her Coumadin was no longer being managed by the home health agency, the physician was sending out the physician 's assistant to draw the laboratory work that was needed to monitor the medication. The patient stated that this change had occurred quite some time ago, she was not sure of the exact time period. The plan of care did not reflect this change and the clinical record lacked evidence of this change to the plan of care through verbal orders or communication to the physician.			G 159			
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This STANDARD is not met as evidenced by: Based on clinical record review, agency staff failed to alert the physician to changes in the patient's condition which suggested a need to alter the plan of care in 1 of 27 records reviewed. (#17)			G 164			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297068		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2009	
NAME OF PROVIDER OR SUPPLIER CARING NURSES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2968 EAST RUSSELL ROAD LAS VEGAS, NV 89120			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 164	Continued From page 14 Findings include: Patient #17 was admitted on 11/4/08 with diagnoses of diabetes mellitus, neuropathy in diabetes, difficulty walking, multiple myeloma, coronary artery disease, multiple myeloma, and decubitus ulcer. During a home visit on 1/7/09, the home health nurse treated a wound on the left arm with the following treatment: cleansed with normal saline, applied Mupirocin 2% ointment and covered with Telfa wrapped with Kerlix and net applied. The clinical record lacked documented evidence that the nurse promptly alerted the physician about the need to alter the plan of care.			G 164			
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. This STANDARD is not met as evidenced by: Based on clinical record review, the agency failed to administer drugs and treatments only as ordered by the physician for 2 of 27 sampled patients. (#17, #6) Findings include: Patient #17 was admitted on 11/4/08 with diagnoses of diabetes mellitus, neuropathy in diabetes, difficulty walking, multiple myeloma, coronary artery disease, and decubitus ulcer. During a home visit on 1/7/09, the home health nurse treated a wound on the left arm with the			G 165			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2009
NAME OF PROVIDER OR SUPPLIER CARING NURSES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2968 EAST RUSSELL ROAD LAS VEGAS, NV 89120		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 165	Continued From page 15 following treatment: cleansed with normal saline, applied Mupirocin 2% ointment and covered with Telfa wrapped with Kerlix and net applied. The clinical record lacked documented evidence to verify the nurse obtained a physician's order prior to the initiation of wound treatment. Patient #6 was admitted to the agency on 10/13/07 and continued to be seen for over a one year period by the agency. The current plan of care for Patient #6 was dated 12/06/08 through 2/03/09 with diagnoses of fitting urinary devices, urinary incontinence, and deep vein thrombosis, diabetes without complications, hypertension, muscle weakness and difficulty with ambulation. The patient was being seen three times a week by skilled nursing. The plans of care for the last three certification periods listed the treatment ordered as " change FC 16/30cc Q 2wks, flush twice a week with 50cc NS times 3 until clean " (change the Foley catheter every two weeks and flush the catheter twice a week for 50 cc of normal saline three times until the fluid coming out of the catheter is clear). During clinical record review it was noted that the patient ' s Foley catheter was being flushed every visit by the registered nurse with normal saline three times until clear. This was being done consistently three times a week. The catheter had been changed on 10/18/08, 11/04/08, 11/11/08, 11/29/08 and 1/01/09. The catheter was not changed every 2 weeks as ordered on the plan of care. The clinical record lacked documentation of orders or contact with the physician to inform him of the changes to the plan of care for this patient.	G 165			
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE	G 176			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2009
NAME OF PROVIDER OR SUPPLIER CARING NURSES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2968 EAST RUSSELL ROAD LAS VEGAS, NV 89120		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 176	<p>Continued From page 16</p> <p>The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p> <p>This STANDARD is not met as evidenced by: Based on record review, patient and staff interview, the agency failed to ensure the registered nurse coordinated services with the home health aide in 4 of 27 patients in the sample. (#7, #17, #6, #9)</p> <p>Findings include:</p> <p>Patient #7 was admitted on 10/28/08 with diagnoses of aftercare for healing trauma, abnormality of gait, muscle weakness, other specified organic brain syndrome, hypertension, and unspecified osteoporosis.</p> <p>Patient #7 plan of care dated, 10/28/08 through 12/26/08 revealed: Skilled nurse to observe and assess: Muscle weakness that may lead to decrease functional ability and high risk for falls. hypertension that may lead to dizziness, headache, fatigue, and palpitation. Patient #7 plan of care revealed: assess vital signs and all body systems, blood pressure: notify MD if systolic over 190 or under 80- diastolic over 100 or under 50; temperature: notify MD if temperature over 101 or under 96; respirations: Notify MD if respirations over 30 or under 10; Heart rate: Notify MD if heart rate over 120 or under 56.</p> <p>The plan of care dated, 10/28/08 through 12/26/08 revealed: Home health aide visit frequency: one time a week for nine weeks A</p>	G 176			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2009
NAME OF PROVIDER OR SUPPLIER CARING NURSES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2968 EAST RUSSELL ROAD LAS VEGAS, NV 89120		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 176	<p>Continued From page 17</p> <p>review of the home health aide care plan instructed the aide to take the temperature every visit. The clinical record lacked documented evidence to verify the skilled nurse instructed the home health aide to obtain vital signs related to the patient's diagnosis of hypertension and vital sign parameters identified on the plan of care.</p> <p>Patient #17 was admitted on 11/4/08 with diagnoses of diabetes mellitus, neuropathy in diabetes, difficulty walking, multiple myeloma, coronary artery disease, and decubitus ulcer.</p> <p>Patient #17 plan of care dated, 11/4/08 through 1/2/09, revealed: assess vital signs and all body systems. The treatment included: Blood Pressure: Notify MD if systolic over 190 or under 80- diastolic over 100 or under 50; Temperature: Notify MD if temperature over 101 or under 96; Respirations: Notify MD if respirations over 30 or under 10; Heart rate: Notify MD if heart rate over 120 or under 56.</p> <p>The plan of care dated, 11/4/08 through 1/2/09 revealed: Home health aide visit frequency: two times a week for four weeks; one time a week for weeks. A review of the home health aide care plan instructed the aide to take the temperature every visit. The clinical record lacked documented evidence to verify the skilled nurse instructed the home health aide to obtain vital signs related to the patient's diagnosis of coronary artery disease and parameters identified on the plan of care.</p> <p>The plan of care, dated 11/4/08 indicated the patient had Port-A- Cath care at the MD office. A home visit was conducted on 1/07/09. During an interview with the spouse, patient and home health nurse on 1/7/09, the surveyor asked when</p>	G 176			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2009
NAME OF PROVIDER OR SUPPLIER CARING NURSES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2968 EAST RUSSELL ROAD LAS VEGAS, NV 89120		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 176	<p>Continued From page 18</p> <p>the patient was last seen by the physician. The spouse stated the patient was seen a few weeks ago. The surveyor asked the nurse about the Port a cath care provided by the home health agency between physician's visits. The nurse thought the oncologist office was caring for it. The clinical record lacked documented evidence to verify the nurse coordinated care with the oncologist's office regarding Port- A- Cath care.</p> <p>Patient #6 was admitted to the agency on 10/13/07 and continued to be seen for over a one year period by the agency. The current plan of care for Patient #6 was dated 12/06/08 through 2/03/09 with diagnoses of fitting urinary devices, urinary incontinence, and deep vein thrombosis, diabetes without complications, hypertension, muscle weakness and difficulty with ambulation. The patient was being seen three times a week by skilled nursing.</p> <p>The patient was to take Clonidine 0.1mg 1 tablet orally every day as needed for a systolic blood pressure of >160. (The top number of the blood pressure is greater than 160) During the interview, the patient stated that she was not taking her own blood pressure. The patient then went on to describe symptoms she would identify as problems with her hypertension such as dizziness and possible nausea. These symptoms also can indicate a problem with blood sugar levels. In the plans of care for the last 3 certification periods, under treatment, " blood glucose (sugar): notify MD if B.S. is >400 or <50 " was listed. There were no blood sugars listed in the record for visits made from 10/04/08 through 1/05/09. The clinical record lacked documented evidence of communication between the</p>	G 176			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2009
NAME OF PROVIDER OR SUPPLIER CARING NURSES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2968 EAST RUSSELL ROAD LAS VEGAS, NV 89120		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 176	<p>Continued From page 19</p> <p>physician and the registered nurse regarding this issue.</p> <p>Patient #9 was admitted to the agency on 8/27/08 with diagnoses including arteriosclerotic dementia with delirium, muscle weakness, and urinary tract infection. When interviewed on 1/7/08 at 2:00 PM the patient was oriented to herself only. She was not oriented to place and repeatedly asked, "where am I, in the hospital".</p> <p>Patient #9 had been visited by the nurse weekly and the nurse made the following observations:</p> <ul style="list-style-type: none"> - 9/11/08 at 10:45 AM, patient "has not eaten breakfast." - 9/17/08 at 1:00 PM, patient "has not eaten breakfast or lunch yet, no food in the fridge." - 9/25/08 at 12:45 PM, patient "has not eaten today, called to have food brought to room." - 10/7/08 at 10:00 AM, patient "did not eat breakfast today." - 10/13/08 at 3:00 PM, patient "has not had any food since last evening. Observation and assessment by skilled nurse reasonable and necessary for today's visit due to a likelihood of changes in patients condition , decreased in nutritional status, weight loss, skin breakdown as a result of the patient sleeping through most meals and not calling to have food delivered. " - 10/21/08 at 4:15 PM, patient "refuses to get out of bed during the day gets up around 8-10 PM and requests food when she wakes up. Message left for daughter regarding providing snack or stocking refrigerator with some food for when she 	G 176			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2009
NAME OF PROVIDER OR SUPPLIER CARING NURSES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2968 EAST RUSSELL ROAD LAS VEGAS, NV 89120		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 176	Continued From page 20 wakes and the cafeteria is closed." - 10/29/08 at 2:00 PM, the patient "unsure if she has eaten today. No food in the refrigerator or in cabinets. Called patient's daughter for concerns of patient not having food available. Patient sometimes only has one snack/meal a day if she wakes up late." - 11/7/08 at 12:30 PM, the patient "has not eaten yet today, no snacks or food in the apartment, left message with director and daughter regarding continued concerns of patient eating only one meal a day." Her weight on admission to the agency was 149 pounds. The patient was weighed at her residence on 1/8/09, and was 140 pounds. The clinical record lacked documented evidence of coordination of care for Patient #9 with the assisted living facility and the patient's physician. On 1/7/09 the nurse was interviewed and reported that she had planned to obtain a referral for the social worker because she felt that the patient required a higher level of care. She reported that the patient's daughter did not want to place her mother in a higher level of care. She reported that the patient had began to miss meals and had no food in the refrigerator for only the past two weeks. She reported that she thought the dietician had seen patient #9. The clinical record lacked documented evidence that the patient had been seen by the dietician.	G 176			
G 215	484.36(b)(2)(iii) COMPETENCY EVALUATION & IN-SERVICE TRAI The home health aide must receive at least 12 hours of in-service training during each 12 month	G 215			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2009
NAME OF PROVIDER OR SUPPLIER CARING NURSES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2968 EAST RUSSELL ROAD LAS VEGAS, NV 89120		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 215	Continued From page 21 period. The in-service training may be furnished while the aide is furnishing care to the patient. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, it was determined that agency failed to ensure that the home health aides were provided 12 hours of in-service training during each 12 month period for the past two years. Findings include: Review of personnel records and inservice records for the calendar years of 2007 and 2008 revealed lack of documented evidence that the home health aides had been provided 12 hours of inservice training as required by regulation. An interview with the Director of Patient Care Services/Administrator on 1/08/09 in the AM revealed that there were no other records of inservice training for the home health aides and that the agency was not aware of the 12 hour requirement.	G 215			
G 323	484.20(c)(1) TRANSMITTAL OF OASIS DATA The HHA must electronically transmit accurate, completed, encoded and locked OASIS data for each patient to the State agency or CMS OASIS contractor at least monthly. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, it was determined that the agency failed to electronically transmit OASIS data for each patient the agency provided service to at least monthly.	G 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2009
NAME OF PROVIDER OR SUPPLIER CARING NURSES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2968 EAST RUSSELL ROAD LAS VEGAS, NV 89120		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 323	Continued From page 22 Findings include: Prior to the survey, reports are run to assist in the survey process. The report titled "Submission statistics by agency", for the time period 7/01/08 through 12/31/08, revealed the following: OASIS submissions were done for the dates of 7/25/08, 9/08/08, 12/03/08, 12/22/08 and 12/29/08. There were no submissions for the months of 08/08, 10/08 and 11/08. There were more than 31 days between the submissions of 7/25/08 and 9/08/08, and 9/08/08 and 12/03/08. An interview conducted on 1/05/09 during the entrance interview with the staff member responsible for the OASIS transmission and the Chief Operating Officer revealed that the transmissions had not been done as required by regulation.	G 323			
G 324	484.20(c)(2) TRANSMITTAL OF OASIS DATA The HHA must, for all assessments completed in the previous month, transmit OASIS data in a format that meets the requirements of paragraph (d) of this section. This STANDARD is not met as evidenced by: Based on reports obtained prior to the survey date, the agency failed to submit collected patient assessments within the CMS timing guidelines. The submission date of the records is more than 30 days from the completion date. Findings include: Prior to the survey date, a report titled error summary report by HHA (Home Health Agency) was generated as part of the pre-survey data	G 324			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2009
NAME OF PROVIDER OR SUPPLIER CARING NURSES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2968 EAST RUSSELL ROAD LAS VEGAS, NV 89120		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 324	Continued From page 23 collection. The report listed the number of errors generated over the time span of 7/01/08 and 12/31/08. There were 5467 errors recorded on this report, 3236 of which dealt with error #286 - Inconsistent MO090/submission date: The submitted assessment was not submitted within CMS timing guidelines. The submission date is more than 30 days from the MO090 (completion date). The percentage of assessments with the error was 92.38%.	G 324			
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on interview of patients during home visits, interview of staff, and clinical record review, the agency failed to ensure that the comprehensive assessment included a review of all medications the patients were currently taking in 6 of 27 sampled patients. (#7, #17, #19, #24, #6, #10) Findings include: Patient #7 was admitted on 10/28/08 with diagnoses of other reduction of fracture, muscle weakness, hypertension, unspecified osteoporosis, traumatic fracture, idiopathic scoliosis and history of falls. During a home visit on 1/6/09, it was noted the patient lived with the son and daughter-in-law. The daughter-in-law administered the patient's	G 337			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2009
NAME OF PROVIDER OR SUPPLIER CARING NURSES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2968 EAST RUSSELL ROAD LAS VEGAS, NV 89120		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 337	<p>Continued From page 24</p> <p>medications. The medication profile did not match the medications which were given in the home. The patient was taking Klor-Con 20mg. one time daily, Multi-vitamin one time daily, Super B tablet one time a day, and Calcium 500mg. with Vitamin D 400 international units chewable one time a daily. The update medication profile list, dated 12/23/08 did not include these medications.</p> <p>Patient #17 was admitted on 11/4/08 with diagnoses of diabetes mellitus, neuropathy in diabetes, difficulty walking, multiple myeloma, coronary artery disease, multiple myeloma, and decubitus ulcer.</p> <p>A home visit was conducted on 1/07/09. The updated plan of care, dated 12/29/08 did not match the medication taken by the patient in the home. The following medications were listed on the Updated Medication Profile were not provided to the surveyor during the medication review in the home.</p> <p>Lovoxyl 0.137mg one tablet daily; Demeclocycline 150 mg Colace 100mg. one tablet daily by mouth prn (as needed) for constipation Paxil 75mg. by mouth daily</p> <p>On 1/7/09, an interview with the patient, spouse and home health nurse indicated the patient was on Novolin Pen 70/30 20 units in the am and 10 units in the PM and Demeclocycline 150mg. one tablet by mouth three times a day. The Updated Medication Profile, dated 12/29/08 revealed Novolin 70/30 15 units subcutaneously twice a day and Demeclocycline 150mg one tablet twice daily.</p>	G 337			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2009
NAME OF PROVIDER OR SUPPLIER CARING NURSES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2968 EAST RUSSELL ROAD LAS VEGAS, NV 89120		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 337	<p>Continued From page 25</p> <p>The clinical record lacked documented evidence to verify the skilled nurse included a review of all medications the patient was currently using to identify any potential adverse effects and drug reactions.</p> <p>Patient #19 was admitted 3/15/08 with a primary diagnosis of malignant neoplasm of the lung.</p> <p>The plan of care for the 11/10/08 - 1/8/09 certification period revealed the patient was ordered Lysine 500 milligrams by mouth daily and Captopril 100 milligrams by mouth twice daily. The clinical record lacked documented evidence of an order for Topamax 25 milligrams by mouth twice daily.</p> <p>The Medication Profile reviewed during a home visit conducted 1/7/09 at 3:30 PM revealed the following:</p> <ol style="list-style-type: none"> 1. Lysine was discontinued on 10/1/08. 2. Captopril was not listed as one of the current medications 3. Topamax 25 milligrams by mouth twice daily was listed as one of the current medications <p>The nurse and the patient both confirmed that the patient's current medication orders were correct on the Medication Profile but not in the clinical record.</p> <p>Patient #24 was admitted on 11/24/08 with diagnoses including malignant neoplasm of the breast, rheumatoid arthritis, fibromyalgia, and idiopathic peripheral neuropathy.</p> <p>Patient #24's plan of care dated 11/24/08 through 1/22/09, listed the following:</p> <ul style="list-style-type: none"> - Lortab 10/500 (hydrocodone 10 mg/milligrams 	G 337			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2009
NAME OF PROVIDER OR SUPPLIER CARING NURSES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2968 EAST RUSSELL ROAD LAS VEGAS, NV 89120		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 337	<p>Continued From page 26</p> <p>and acetaminophen 500 mg) 1 tab (tablet) po (by mouth) Q (every) 4 - 6 hours prn (as needed) for pain, and</p> <p>- medication allergies to methadone, morphine, and fentanyl.</p> <p>The clinical record lacked documented evidence the drug regimen review was evaluated for potential adverse effects or drug reactions from the ordered Lortab and reported patient allergies to methadone, morphine, and fentanyl. Patient #6 was admitted to the agency on 10/13/07 and continued to be seen for over a one year period by the agency. The current plan of care for Patient #6 was dated 12/06/08 through 2/03/09 with diagnoses of fitting urinary devices, urinary incontinence, and deep vein thrombosis, diabetes without complications, hypertension, muscle weakness and difficulty with ambulation. The patient was being seen three times a week by skilled nursing.</p> <p>During the home visit conducted on 1/06/09 at 2:00 PM, the medication list in the record did not match the medications being taken by the patient. The patient was interviewed during the visit about her medications. The plan of care dated 12/06/08 through 2/03/09 listed Oxytrol patch 1 patch transdermally every 72 hours, the patient stated that that medication was discontinued over 6 month ' s ago. The plan of care also listed aspirin 81mg one tablet orally everyday. The patient stated that she had stopped taking that medication twelve months ago. Motrin 400mg 1 tablet orally every 6 hours as needed for pain. The patient stated that she had also stopped taking the Motrin. The patient stated that she had been using Nystatin 100mu/gm powder in the</p>	G 337			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2009
NAME OF PROVIDER OR SUPPLIER CARING NURSES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2968 EAST RUSSELL ROAD LAS VEGAS, NV 89120		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 337	<p>Continued From page 27</p> <p>creases under her breasts and at her groin for " a long time " , yet this medication was not listed on the plans of care for the last 3 certification periods.</p> <p>Patient #10 was admitted to the agency on 3/26/08. The patient continued on services with many recertification periods. The plan of care dated 11/21/08 through 1/19/09 listed as diagnoses obstructive chronic bronchitis with acute exacerbation, cervical disc degeneration, personal history of pneumonia, anxiety, anemia, muscle weakness and diarrhea.</p> <p>A home visit was conducted on 1/06/09 at 12:10 PM. The medication profile in the clinical record and the medication actually being taken by the patient did not agree. The medications listed in the clinical record that differed from what the patient was taking were as follows: O2 @ 2L/NC CONT, the patient was on 3.5 liters of oxygen during the visit. Pravastatin 20 milligrams one tablet orally at bedtime, the patient denied taking currently. Metoclopramide 10 milligrams one tablet orally four times a day, the patient denied taking currently. Clonazepam 1 milligram one tablet orally twice a day as needed for anxiety, the patient denied taking currently. Trazodone 150 milligrams two tablets orally every night, the patient denied taking currently. Oxycodone Hcl 15 milligrams one tablet orally three times a day as needed for pain, the patient denied taking currently. Aspirin 81 milligrams one tablet orally one time a day, the patient denied taking currently. Lasix 20 milligrams one tablet orally one time a day, the patient denied taking currently.</p>	G 337			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2009
NAME OF PROVIDER OR SUPPLIER CARING NURSES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2968 EAST RUSSELL ROAD LAS VEGAS, NV 89120		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 337	Continued From page 28 Celebrex 200 milligrams one tablet orally every day, the patient denied taking currently. Ativan 1 milligram one tablet orally twice a day, the patient denied taking currently. Ibuprofen 800 milligrams one tablet orally every six hours as needed for pain, the patient denied taking currently. Klonopin 0.1 milligrams one tablet orally three times a day, the order changed one month ago to four times a day. The medication the patient was taking that were not in the clinical record were as follows: Temazepam 30 milligrams one time a day Butalbital-APAP-caffeine for head ache as needed Hydroxyzine 50 milligrams orally one time a day Seroquel 200 milligrams orally one time a day Azithromycin 250 milligrams as needed per MD direction Hydroxyzine 50 milligrams orally one time a day Vitamin D orally one time a day Vitamin E orally one time a day Vitamin B complex orally one time a day Calcium orally one time a day Vitamin C orally one time a day Centrum silver orally one time a day The plan of care had skilled nursing ordered for twice a week through the certification period. The clinical record lacked documentation of changes to the medication profile as required by regulation.	G 337			
G 341	484.55(d)(3) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) at discharge.	G 341			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2009
NAME OF PROVIDER OR SUPPLIER CARING NURSES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2968 EAST RUSSELL ROAD LAS VEGAS, NV 89120		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 341	<p>Continued From page 29</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and clinical record review, the agency failed to demonstrate that a discharge OASIS (outcome assessment information set) was completed in a timely manner and by the appropriate discipline for 1 of 27 records reviewed. (#3)</p> <p>Findings include:</p> <p>Patient #3 was admitted to the agency on 7/12/08 with diagnoses of diabetes without complications, muscle weakness, hypertension and organic brain syndrome.</p> <p>During record review it was revealed that the clinical record contained two entries of verbal orders regarding discharge of the patient from clinical services. The first order was effective on 8/26/08 and revealed " Discharge from HH services by CNI " (discharge from home health services by CNI). The discipline noted on the verbal order was for skilled nursing.</p> <p>The second order was effective on 8/28/08 and revealed " Patient discharged from home physical therapy " . Further review of the record revealed that the last visit made by skilled nursing was documented on 8/26/08, with the discharge OASIS being completed by the registered nurse on 8/28/08. The last visit made to the patient by the physical therapist was dated 8/28/08.</p> <p>Interview with the Director of Patient Care Services/Administrator conducted on 1/08/09 at 11:00 AM revealed that the registered nurse who completed the OASIS discharge document had done so with information that was obtained over</p>	G 341			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297068		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2009	
NAME OF PROVIDER OR SUPPLIER CARING NURSES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2968 EAST RUSSELL ROAD LAS VEGAS, NV 89120			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 341	Continued From page 30 the telephone. The OASIS discharge was not completed on site by the physical therapist as required.			G 341			